| Student's Name Last | First | Middle | Birth Date Month Day Year | Sex | School | Grade Level/ ID # |
|---|---|---|---|---|---|---|
| | | | | | | |

## HEALTH HISTORY

TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

| | Circle one | Comments | | Circle one | Comments |
|---|---|---|---|---|---|
| Diagnosis of Asthma?<br>Wheeze/Cough During or After Play? | Yes O No O<br>Yes O No O | Indicate Severity: | Loss of Function of One of Paired Organs? (Eye/Ear/Kidney/Testicle) | Yes O No O | |
| Birth Defects? | Yes O No O | | Hospitalizations?<br>When? What for? | Yes O No O | |
| Developmental Delay? | Yes O No O | | | | |
| Blood Disorders? Hemophilia, Sickle Cell, Other? Explain | Yes O No O | | Surgery? (List All)<br>When? What For ? | Yes O No O | |
| Diabetes? | Yes O No O | | Serious Injury or Illness? | Yes O No O | |
| Head Injury/Concussion/Passed Out? | Yes O No O | | TB Skin Test Positive (Past or Present)? | Yes* O No O | * Refer positive response to the local health department. |
| Seizures? What are they like? | Yes O No O | | TB Disease (Past or Present)? | Yes* O No O | |
| Heart Problem/Shortness of Breath? | Yes O No O | | Tobacco Use (Type, Frequency)? | Yes O No O | |
| Heart Murmur/High Blood Pressure? | Yes O No O | | Alcohol/Drug Use? | Yes O No O | |
| Dizziness or Chest Pain With Exercise? | Yes O No O | | Family History of Sudden Death Before Age 50? (Cause?) | Yes O No O | |
| Bone/Joint Problems/Injury?<br>Scoliosis? | Yes O No O | | Dental ☐Braces ☐Bridge ☐Plate Other | | |
| | | | Other Concerns? | | |
| Ear/Hearing Problems? | Yes O No O | | **Information on this form may be shared with appropriate personnel for health and educational purposes.** | | |
| Eye/Vision Problems? Glasses Contacts Last Exam _____<br>Other Concerns? | | | **Parent/Guardian Signature** **Date** | | |

## TO BE COMPLETED BY MD/APN/PA

(* INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES OR SELECTED SCHOOLS AND PROGRAMS)

| Strongly Recommended Tests | Date | Results | | Date | Results |
|---|---|---|---|---|---|
| Hemoglobin * or | | | Urinalysis | | |
| Hematocrit * | | | Sickle Cell * (as needed) | | |

**Lead Questionnaire*** Completed? Yes ◯ No ◯ Date Blood Test Indicated? Yes ◯ No ◯ Blood Test Performed? Yes ◯ No ◯

**TB Skin Test** Recommended only for children in high-risk groups: includes children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. **Date Read / / Result mm**

## PHYSICAL EXAMINATION REQUIREMENTS

HEIGHT WEIGHT B/P HEART RATE

| | Normal | Comments/Follow-up/Needs | | Normal | Comments/Follow-up/Needs |
|---|---|---|---|---|---|
| Skin | | | Endocrine | | |
| Ears | | | Gastrointestinal | | |
| Eyes | | | Genito-Urinary | | LMP |
| Nose | | | Neurological | | |
| Throat | | | Musculoskeletal | | |
| Mouth/Dental | | | Spinal Examination | | |
| Cardiovascular/HTN | | | Nutritional Status | | |
| Respiratory | | | Mental Health | | |

**ALLERGIES (Food, drug, insect, other)**

**MEDICATION (List all prescribed or taken on a regular basis.)**

**NEEDS/MODIFICATIONS required in the school setting**

**DIETARY Needs/Restrictions**

**SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic supporter/cup**

**MENTAL HEALTH/OTHER: Is there anything else that you think the school should know about this student?**

**If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal**

**EMERGENCY ACTION needed while at school due to child's health condition (e.g. seizures, asthma, insect sting. food, peanut allergy, bleeding problem, diabetes, heart problem)?**

**Yes ☐ No ☐ If yes, please describe:**

**On the basis of the examination on this day, I approve this child's participation in: (If No or Modified, please attach explanation.)**

**PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ INTERSCHOLASTIC SPORTS (for one year) Yes ☐ No ☐ Limited ☐**

**Physician/Advanced Practice Nurse/Physician Assistant performing examination**

**Print Name** **Signature** **Date**

**Address** **Phone**